MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02712

CERTIFICATE OF DEATH

Reg. Dist. No. 91

1. PLACE OF DEATH:
County: Cecil
City or town: Rural Near Chesapeake City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 Yrs.
Hospital, institution, or street address where death occurred:
Chesapeak City, Md R.D.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Rural - Chesapeake City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Addie Andrews

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Col.	Widowed

6.(b) Name of husband or wife: —
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 20, 1886

8. AGE: Years	Months	Days	If less than one day
60	3	0	..... hrs. ..... min.

9. Birthplace: Cecil Co. Md (Town, county, and state)
10. Usual occupation: at Home
11. Industry or business

MOTHER FATHER
12. Name: Henry Gibbs
13. Birthplace: Cecil Co. Md
MOTHER
14. Maiden name: Liza Bradley
15. Birthplace: Harford Co

16. Informant: Charles Long
Address: 707 Fontain Place Phila Pa
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/23/47 (month) (day) (year)
Cemetery or crematory: Manor
Location: Near Chesapeake City, Md
18. Funeral director: H. L. Peppin
Address: Elkton, Md.
19. March 22 1947 (Date rec'd by registrar) Ira Ralph H. Hall Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3/20/47, 19..., at 2:05 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-15- 1947 to 3-20- 1947
and that I last saw h... alive on 3-20- 1947

Immediate cause of death	DURATION
Chronic myocarditis	3-4
Due to	Yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Elkton Md Date signed 3/21/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (6)

CERTIFICATE OF DEATH

Reg. Dist. No. 960

1. PLACE OF DEATH:
County: Cecil
City or town: Port Deposit
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30y
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Port Deposit Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: John Joseph Caffrey

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 25, 1946

8. AGE: Years | Months: 11 | Days: 28 | If less than one day: hrs. min.

9. Birthplace: Havre de Grace, Harford, Md
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: John C. Caffrey
13. Birthplace: New York, N. Y.

MOTHER
14. Maiden name: Marie A. Lied
15. Birthplace: Port Deposit, Md

18. Informant: John C. Caffrey
Address: Port Deposit, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-30-47 (month) (day) (year)
Cemetery or crematory: Mt. Erin
Location: Havre de Grace, Md. Rural

18. Funeral director: Lee A. Catterson & Son
Address: Perryville, Md.

19. 3/30/47 (Date rec'd by registrar) Irene E. Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 30, 1947, at 6:10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-29-1947, to 3-30-1947 and that I last saw h... alive on 3-30-1947

Immediate cause of death: Epidemic Meningitis

Due to: Cause unknown

Due to: Child died four hours after doctor was called.

Other conditions

(Include pregnancy within 3 months of death)

DURATION
9 hrs.

Major findings of operations

Date of op.

Autopsy results: No autopsy was permitted.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Port Deposit Date signed 3-30-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1 — 55

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462)

CERTIFICATE OF DEATH

Chamberlain 02713

Reg. Dist. No. 960

1. PLACE OF DEATH:
County: Cecil
City or town: Perryville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? About 50 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Perryville,
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Anna B. Chamberlain

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Thomas Chamberlain
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 26, 1869

8. AGE: Years	Months	Days	If less than one day
77	9	2	..... hrs. ..... min.

9. Birthplace: Port Deposit, Cecil Co., Md.
(Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business

FATHER
12. Name: John B. Campbell
13. Birthplace: Cecil Co., Md.

MOTHER
14. Maiden name: Anna M. Foster
15. Birthplace: Cecil Co., Md.

16. Informant: Mrs May Hornberger
Address: Perryville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 31 1947 (month) (day) (year)
Cemetery or crematory: Asbury
Location: Perryville, Md. Rural

18. Funeral director: Lee A. Patterson & Son
Address: Perryville, Md.

19. 3/30 1947 Irene E. Dempsey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 28 March 1947 at 5:05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1946 to March 1947 and that I last saw h.. alive on 28 March 1947

Immediate cause of death	DURATION
Cardiac Failure	
Due to Cachexia	
Due to Carcinoma (Rectum)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Adenocarcinoma of Rectum Date of op. 31 Jan '47
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: W H Sadowsky MD M. D. or other
Address: Perryville, Md. Date signed 28 Mar 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (732)

CERTIFICATE OF DEATH

Reg. Dist. No. 960

Bureau 02714

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Cecil
City or town: Perryville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Perryville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Edith May Cochran

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Unknown 1862

8. AGE: Years: about 85 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Perryville, Cecil, Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

MOTHER FATHER
12. Name: Dr. John Cochran
13. Birthplace: Cecil Co., Md
14. Maiden name: Caroline Owens
15. Birthplace: Perryville, Cecil Co., Md.

18. Informant: Myrtle Cole
Address: Perryville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 1, 47 (month) (day) (year)
Cemetery or crematory: Principio
Location: Principio Furnace Md.

18. Funeral director: Lee A. Catterson & Son
Address: Perryville, Md.

19. April 1 1947 Irene E. Daughton
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 29 1947, at 6:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec - 12 1946, to March 28 1947.
and that I last saw her alive on March 28 - 1947

Immediate cause of death	DURATION
Chronic Myocarditis.	8 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. P. Benson M.D.
M. D. or other
Address: Port Depot. Md. Date signed 3/30/47.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 56-6

CERTIFICATE OF DEATH

Reg. Dist. No. 02715 2750

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 Days
Hospital, institution, or street address where death occurred: Union Hospital
How long in hospital or institution? 12 Days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Chesapeake City (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Agnes Merrell Collins

3.(b) Social Security Number:

4. Sex: Female
5. Color or race: white
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Louis Collins
6.(c) If alive, give age: 40 years
7. Birth date of deceased (mo., day, yr.): Jan. 4, 1908
8. AGE: Years: 39 Months: 1 Days: 24 If less than one day: hrs. min.
9. Birthplace: Warwick, Cecil, Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Richard B. Merritt Jr.
13. Birthplace: Warwick, Md.
MOTHER 14. Maiden name: Bessie B. Boshot
15. Birthplace: Warwick, Md
16. Informant: Louis Collins
Address: Chesapeake City, Md
17. Burial, cremation, or removal. Which?: Burial Date thereof: 3-4-47 (month) (day) (year)
Cemetery or crematory: Bethel Cemetery
Location: Near Chesapeake City
18. Funeral director: H. W. Pippin & Son
Address: Elkton, Md.
19. (Date rec'd by registrar): Mar 4 1947 FR Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 1 1947 at 10 45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 18 1947 to March 1 1947 and that I last saw h[illegible] alive on March 1 1947

Immediate cause of death	DURATION
Intestinal obstruction	4 days
Due to, Hysterectomy	9 days
Due to, Fibro myoma Uterus	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Fibro myoma Uterus Date of op. Feb. 20, 1947

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. J. Davis M.D. M. D. or other
Address: Chesapeake City Md. Date signed: 3/4/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

Reg. Dist. No. 027160

1. PLACE OF DEATH:
County Cecil Co.,
City or town Conowingo Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 31 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Cecil, Co.
City or town Conowingo Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Melvin Eastridge

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Mary Eastridge
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 17 - 1863

8. AGE: Years 83 | Months 9 | Days 18 | If less than one day ..... hrs. ..... min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER
12. Name Henry Eastridge
13. Birthplace North Carolina

MOTHER
14. Maiden name Elizabeth Johnson
15. Birthplace North Carolina

16. Informant David Eastridge
Address Liberty Grove Md.

17. (Burial, cremation, or removal. Which?) Burial Date thereof Mar 10 1947 (month) (day) (year)
Cemetery or crematory Baptist Cem
Location Conowingo Md.

18. Funeral director J. C. Tyson,
Address Rising Sun Md.

19. Mch 8 1947 19 (Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 7 19 47, at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 - 1 19 47, to 3 - 7 19 47
and that I last saw h.. alive on 3 - 6 - 47 19 47

Immediate cause of death	DURATION
Myocardial fibrosis	Years
Due to Hypertensive Cardio Vascular disease.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other
Address [illegible] Date signed 3-7-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83(a)

CERTIFICATE OF DEATH

02717 60
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Perryville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 30 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Perryville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Harford Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Henry Milton Fadeley

3.(b) Social Security Number: 717 - 07 -5722

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ida Mae Fadeley
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 4, 1881

8. AGE: Years	Months	Days	If less than one day
65	7	15	hrs. min.

9. Birthplace: Havre de Grace, Harford Co., Md
(Town, county, and state)
10. Usual occupation: Locomotive Machinist
11. Industry or business: Penna. R.R.
FATHER 12. Name: William M. Fadeley
13. Birthplace: Virginia.
MOTHER 14. Maiden name: Mary E. Price
15. Birthplace: Harford Co., Md.
16. Informant: Ida Mae Fadeley
Address: Perryville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof March 23, 1947 (month) (day) (year)
Cemetery or crematory: Angel Hill
Location: Havre De Grace, Harford Co., Md
18. Funeral director: Lee A. Patterson & Son.
Address: Perryville, Md.
19. March 23 19 47 Irene E. Daugherty (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 19 1947 at 9 P. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 16 1947, to March 19 1947
and that I last saw him alive on March 19 1947
Immediate cause of death: Cerebral Haemorrhage — DURATION: 4 Hrs.
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. F. Maginnis M. D. or other
Address: Perryville Md Date signed: 3/21/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

02718

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Celbln
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Nov 19, 1946
Hospital, Institution, or street address where death occurred: Union Hospital Celbln Md
How long in hospital or institution? 4 Mos

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Kent
City or town: Galena
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: V

3.(a) FULL NAME: Freeman- Mrs Rebecca

3.(b) Social Security Number: 218-20-8288

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Wm H. Freeman
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): 1872 - July 3rd

8. AGE: Years 74 | Months 8 | Days 15 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Julian Whitlow
13. Birthplace: Cecil Co. Md.

MOTHER
14. Maiden name: Sara May
15. Birthplace: Cecil Co. Md.

16. Informant: Mrs Rebecca Freeman
Address: Union Hosp- Celbln Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 25 47 (month) (day) (year)
Cemetery or crematory: Galena
Location: Galena Md.
18. Funeral director: Edward Fellows
Address: Millington, Md.

19. Mar 27 1947 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 21, 1947, at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 19, 1946, to March 21, 1947 and that I last saw h- alive on March 21, 1947

Immediate cause of death: Cerebral Thrombosis

DURATION

Due to: Carcinoma of Left Breast 4 years

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Inoperable Carcinoma Date of op. None

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. Clellan Cruikshank M.D.
M. D. or other
Address: Centreville Md Date signed: Mar 21/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

02719

Reg. Dist. No. 920

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Belvidere Del R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 32 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Belvidere R.F.D.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Hester S. Harrington

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife: William H. Harrington
6.(c) If alive, give age: 74 years
7. Birth date of deceased (mo., day, yr.): Aug 12 - 1868

8. AGE: Years: 78 | Months: 7 | Days: 9 | If less than one day: hrs. min.

9. Birthplace: Bay View Md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Jessie Janney
13. Birthplace: Bay View.

MOTHER
14. Maiden name: Isabella Kemble
15. Birthplace: Elkton Md

16. Informant: William H. Harrington
Address: Belvidere Del R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3 (month) 24 (day) 47 (year)
Cemetery or crematory: West Nottingham
Location: Cecil Co Md
18. Funeral director: P. T. Jones
Address: Newark, Del

19. Mar 27 1947 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 24, 1947, at 2:42 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 18 Jan 1947, to 21 Mar 1947; and that I last saw her alive on 21 Mar 1947.

	DURATION
Immediate cause of death: acute intersticial nephritis.	?
Due to: Arteriosclerosis general with cerebral hemorrhage.	5 yrs. 4 mo.
Due to:	
Other conditions: Chronic valvular heart disease.	?

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Wallace W Johnson M.D.
M. D. or other
Address: Newark Del Date signed: 3/27/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 166

CERTIFICATE OF DEATH

02720

Reg. Dist. No. 920

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 0

Hospital, Institution, or street address where death occurred: 365 W. Main St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

Street No. 365 W. Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war: World War II

3. (a) FULL NAME Leonard Kist

3. (b) Social Security Number 216-16-5500

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Married

6.(b) Name of husband or wife: Reta Kist

6.(c) If alive, give age: 20 years

7. Birth date of deceased (mo., day, yr.): May 9, 1924

8. AGE: Years	Months	Days	If less than one day
22	10		hrs. min.

9. Birthplace: Kulm, N.D. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER 12. Name: Rudulph Kist

13. Birthplace: Europe

MOTHER 14. Maiden name: Lydia Zahn

15. Birthplace: N. D.

16. Informant: Albert Kist

Address: 365 W. Main St Elkton, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 3, 47 (month) (day) (year)

Cemetery or crematory: North East M.E. Cem

Location: North East, Md

18. Funeral director: H.W. Pijanowski

Address: Elkton, Md

19. Mar 31 1947 (Date rec'd by registrar) J R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1947, at 8:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Internal Hemmorhage	
Due to: Perforating wound of Heart & Lung left	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Internal Hem.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Homicide Date of 3-30-47

Where did injury occur? Elkton (City or town) Cecil (County) Md. (State)

Injured at home, farm, industry, public place (where?): Home.

Means of injury: Pistol Injured at work?

23. SIGNATURE: R L Dodson MD Medical Examiner Cecil County

Address: Rising Sun Md M. D. or other

Date signed: 3-30-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

CERTIFICATE OF DEATH

02721

cB Reg. Dist. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Cecil
City or town: Perry Point, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 mos.6 days
Hospital, institution, or street address where death occurred:
Veterans Administration Hospital, Perry Point, Md.
How long in hospital or institution? Brought to this hospital from hospital in Milford, Del. Date of admission there unknown

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Delaware County: Sussex
City or town: Milford
(If outside city or town limits, write RURAL and give nearest town)
Street No. 108 Church Street
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-I

3. (a) FULL NAME: KOSCI, Andrew

3. (b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife: Stella Fowler
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan.10, 1898

8. AGE: Years	Months	Days	If less than one day
49	2	5	..... hrs. ..... min.

9. Birthplace: Scranton, Penna. (Town, county, and state)
10. Usual occupation: Unknown
11. Industry or business
FATHER 12. Name: Unknown - deceased
13. Birthplace
MOTHER 14. Maiden name: Unknown - deceased
15. Birthplace
16. Informant: Hospital Records
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3 - 20 - 47 (month) (day) (year)
Cemetery or crematory: Odd Fellows Cemetery
Location: Milford, Delaware
18. Funeral director: Vela Patterson & Son Perryville Md.
Address For: LOFLAND FUNERAL HOME Milford, Delaware
19. Mar 16 1947 Irene E. Doughty
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 15 1947 at 8:55PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 9 1946 to March 15 1947 and that I last saw him alive on March 15 1947

Immediate cause of death	DURATION
Other diseases of the kidneys - uremia	3 days
Due to	
Due to	
Other conditions: Diabetes mellitus	Unknown
Diarrhea and enteritis	1 week

(Include pregnancy within 3 months of death)

Major findings of operations: --
Date of op.
Autopsy results: --
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -- Date of
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): --
Means of injury: -- Injured at work?

23. SIGNATURE: A. E. Trollinger (M. D. or other)
A. E. TROLLINGER, M.D., Clinical Directo.
Address: Perry Point, Md. Date signed: 3-16-47

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1951)

CERTIFICATE OF DEATH

02722

Reg. Dist. No. 920

1. PLACE OF DEATH:
County Cecil
City or town Fairhill (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County Cecil
City or town Fairhill (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Richard Lee Lanning

3.(b) Social Security Number

4. Sex M
5. Color or race White
6.(a) Single, married, widowed, or divorced Single
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) July 30 1946

8. AGE: Years | Months 8 | Days | If less than one day ... hrs. ... min.

9. Birthplace Elkton Md (Town, county, and state)
10. Usual occupation child
11. Industry or business

FATHER
12. Name Chas. Lanning
13. Birthplace Stanton Va.

MOTHER
14. Maiden name Jeanne Lotts
15. Birthplace Stanton Va.

16. Informant Jeanne Lanning
Address Elkton R.D Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 2 47 (month) (day) (year)
Cemetery or crematory Moores Chapel Cemt.
Location Blake, Md
18. Funeral director H W Pippin
Address Elkton, Md
19. Mar 31 1947 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1947, at 11.05 a M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Strangulation	
Due to Something in wind pipe.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 3-30-47
Where did injury occur? Fairhill. Cecil Md. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury Injured at work?

Medical Examiner Cecil County

23. SIGNATURE R C Dodson MD M. D. or other
Address Rising Sun Md Date signed 3/30-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3d)

02723

CERTIFICATE OF DEATH

Reg. Dist. No. 920

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 46 yrs.
Hospital, Institution, or street address where death occurred: 145 W. High St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Cecil
City or town: ELKTON, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 145 W. High Street.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Miller Fernandus MAGraw

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MAle	white	MArried

6.(b) Name of ~~husband~~ or wife: MAry JAne
6.(c) If alive, give age: 88 years

7. Birth date of deceased (mo., day, yr.): Dec. 6, 1859

8. AGE: Years: 87 | Months: 3 | Days: 5 | If less than one day: hrs. min.

9. Birthplace: Cecil Co. Md.
(Town, county, and state)

10. Usual occupation: Elevator operator

11. Industry or business:

FATHER
12. Name: William Magraw
13. Birthplace: Cecil

MOTHER
14. Maiden name: Eliz. Reed
15. Birthplace: Cecil

16. Informant: Eliz. Esther Scott
Address: 145 W. High Street Elkton

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 14, 1947 (month) (day) (year)
Cemetery or crematory: Cherry Hill
Location: Cherry Hill Md

18. Funeral director: H. W. Pippin
Address: Elkton, Md

19. Mar 12 1947 (Date rec'd by registrar) J R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11 March 1947, at 3:12 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 8 March 1947, to 11 March 1947
and that I last saw h.. l.. alive on 11 March 1947

	DURATION
Immediate cause of death: Cardiac Failure	
Due to: Hypertensive Cardio-vascular Disease	
Due to: Arteriosclerosis — Apoplexy	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: George J Kreiss Jr M. D. or other
Address: Elkton, Md. Date signed: 11 Mar '47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

02724

Reg. Dist. No. 96 0

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: CECIL

City or town: PERRY POINT, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs. 11 mos. 4 das.

Hospital, institution, or street address where death occurred:
VAH, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1111 Longwood Street
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3.(a) FULL NAME: COLUMBUS M. MCGEE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Mrs. Dorothy R. McGee

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 15, 1895

8. AGE: Years	Months	Days	If less than one day
52	2	15	..... hrs. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Guard

11. Industry or business

FATHER
12. Name: S. George McGee - deceased
13. Birthplace: Maryland

MOTHER
14. Maiden name: Sarah Elizabeth Mark- Deceased
15. Birthplace: Maryland

16. Informant: Wife, Mrs. Dorothy R. McGee
Address: 1111 Longwood St., Baltimore, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: March 31, 1947 (month) (day) (year)

Cemetery or crematory: Lorraine Park Cemetery

Location: Woodlawn, Maryland

18. Funeral director: G. HOWARD STRONG
G Howard Strong

Address: 3207 W North Ave, Baltimore, Md.

19. March 31 19 47 (Date rec'd by registrar) Irene E. Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 30 19 47 at 3:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 26, 1943 to March 30 1947 and that I last saw him alive on March 30, 1947

Immediate cause of death	DURATION
Hemorrhage, Cerebral	2 days
Due to: Arteriosclerosis, cerebral	Unknown
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: —

Date of op. .....

Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE: A.E. Trollinger
A.E. TROLLINGER, M.D., Clin. Director

Address: VAH, Perry Point, Md. Date signed: 3-31-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02725

Reg. Dist. No. 96

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County: CECIL

City or town: PERRY POINT, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs. 18 das.

Hospital, institution, or street address where death occurred:
VAH, Perry Point, Maryland

How long in hospital or institution? 4 yrs. 2 mos. 19 das.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: ____ County: ____

City or town: Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1300-44th Pl., S.E.,
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3.(a) FULL NAME: ARTHUR H. MEANS

3.(b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Mrs. Helen Means

6.(c) If alive, give age: --

7. Birth date of deceased (mo., day, yr.): February 26, 1890

8. AGE: Years	Months	Days	If less than one day
57		18	hrs. min.

9. Birthplace: Boston, Mass.
(Town, county, and state)

10. Usual occupation: Lumber Div. in the War Dept.

11. Industry or business:

FATHER
12. Name: Fred H. Means - Deceased
13. Birthplace: Milton, Mass.

MOTHER
14. Maiden name: Barbara Brown - Deceased
15. Birthplace: Beverly, Mass.

16. Informant: Wife, Mrs. Helen Means

Address: 1300-44th Pl., S.E., Washington, D.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: March 5, 1947 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Ft. Myer, Virginia

18. Funeral director: Pennington & Son

Address: Havre de Grace, Maryland

19. March 5 1947 (Date rec'd by registrar) Irene E. Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 4 1947 at 7:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 16 1943 to March 4 1947 and that I last saw him alive on March 4 1947

Immediate cause of death	DURATION
Softening of the brain	More than one year
Due to	
Due to	
Other conditions: Bronchopneumonia	2 weeks

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of: --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): --

Means of injury: -- Injured at work? --

23. SIGNATURE: A. E. Trollinger

Address: A.E. TROLLINGER, M.D., Clin. Director VAH, Perry Point, Md. Date signed: March 5, 1947

Z-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 119-01

CERTIFICATE OF DEATH

02726

Reg. Diat. No. 42

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, Institution, or street address where death occurred: Union Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
Street No. 147 Hollingsworth Manor
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Sandra Lee Mull

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 29, 1947

8. AGE: Years	Months	Days	If less than one day
	1	11	hrs. min.

9. Birthplace: Elkton, Cecil Maryland
(Town, county, and state)
10. Usual occupation: infant
11. Industry or business

FATHER
12. Name: Jacob Allan Mull
13. Birthplace: Providence, Ind.

MOTHER
14. Maiden name: Inez Harmon
15. Birthplace: New Town, W. Va.

16. Informant: Jacob Allan Mull
Address: 147 Hollingsworth Manor Elkton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 13 '47 (month) (day) (year)
Cemetery or crematory: Friends
Location: Calvert, Md

18. Funeral director: Joseph R. Grant
Address: North East Md

19. Mar 12 1947 (Date rec'd by registrar) F. K. Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 12 1947, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 March 1947, to 12 March 1947
and that I last saw h.e.r alive on 11 March 1947

Immediate cause of death	DURATION
Intestinal Hemorrhage	
Due to Colitis, Malnutrition	
Vomiting & Dyspnea	
Due to	
Other conditions Prematurity, Malnutrition	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Geo. J. Kreis Jr. M. D. or other
Address: Elkton, Md. Date signed 12 March '47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02727

131a ★

CERTIFICATE OF DEATH

Reg. Diat. No. 920

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 hrs

Hospital, institution, or street address where death occurred: Union Hospital, Elkton, Md.

How long in hospital or institution? 15 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Zion, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Bertha R. Ramsey

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife: William T. Ramsey

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 18, 1869

8. AGE: Years	Months	Days	If less than one day
77	5	11	..... hrs. ..... min.

9. Birthplace: Calvert, Cecil Co. Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER — 12. Name: Granville Reynolds

FATHER — 13. Birthplace: Calvert, Md.

MOTHER — 14. Maiden name: Ella Mearns

MOTHER — 15. Birthplace: Calvert, Md.

16. Informant: Mrs. Charles Owens

Address: North East, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 1, 1947 (month) (day) (year)

Cemetery or crematory: Rosebank Cemetary

Location: Calvert, Md.

18. Funeral director: Ralph M. Reed

Address: Rising Sun, Md.

19. Mar 31 1947 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 29 1947 at 7:20 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 16 1947 to March 29 1947 and that I last saw h[er] alive on March 25 1947

Immediate cause of death	DURATION
Pneumonia & Hemiplegia	
Due to Cerebral Hemorrhage	
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: R. L. Dodson M.D. M. D. or other

Address: Rising Sun Md. Date signed: 3/30-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1-35

02728

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13F a)

CERTIFICATE OF DEATH

Reg. Dist. No. 9/6

1. PLACE OF DEATH:
County: Cecil
City or town: Chesapeake City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 56 years
Hospital, Institution, or street address where death occurred: Chesapeake City, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Chesapeake City
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Elizabeth C. SAGER

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Wh.	Married

6.(b) Name of husband or wife: J. Sager.
6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): Oct 2, 1890

8. AGE: Years	Months	Days	If less than one day
56	5	5	...hrs. ...min.

9. Birthplace: Chesapeake City, Md (Town, county, and state)
10. Usual occupation: at Home
11. Industry or business

FATHER
12. Name: Augustus Tatmore
13. Birthplace: Chesapeake City, Md

MOTHER
14. Maiden name: Mary Leland
15. Birthplace: Chesapeake City, Md

16. Informant: John Sager
Address: Chesapeake City, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 10 47 (month) (day) (year)
Cemetery or crematory: Bethel near Chesapeake City
Location: Chesapeake City, Md
18. Funeral director: H. W. Lippis
Address: Elkton, Md.

19. March 10 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 7 19 47 at 4:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 19 31 to March 7 19 47 and that I last saw him alive on March 7 19 47

Immediate cause of death	DURATION
Cerebral Hemorrhage	March 4-19 47
Due to Hypertension	15-20 years
Due to Hypertension Cardiovascular Renal disease	10 years
Other conditions Left Hemiplegia	3 days.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: H. V. Davis M.D. M. D. or other
Address: Chesapeake City Md Date signed: 3/8/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

02729

Reg. Dist. No. CB 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Cecil
City or town Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 44 hours.
Hospital, institution, or street address where death occurred: Union Hospital Elkton Md
How long in hospital or institution? 44 hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Pa. County Bucks.
City or town Morrisville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war V

3. (a) FULL NAME William Mathews Seisel Seisel

3. (b) Social Security Number

4. Sex: M.
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Josephine Seisel
6.(c) If alive, give age: 39 years
7. Birth date of deceased (mo., day, yr.): Feb-17-1907.
8. AGE: Years: 40 Months: Days: 26 If less than one day: hrs. min.
9. Birthplace: Mt Kisco N.Y. (Town, county, and state)
10. Usual occupation: Consult Eng.
11. Industry or business:
FATHER 12. Name: Wm. Seisel
13. Birthplace: Albany N.Y.
MOTHER 14. Maiden name: Elizabeth Mathews
15. Birthplace: Mt Kisco N.Y.
16. Informant: Josephine Seisel
Address: Morrisville Pa.
17. Cremation (Burial, cremation, or removal. Which?) Date thereof 3/18/47 (month) (day) (year)
Cemetery or crematory: Trenton
Location: Trenton N.J.
18. Funeral director: H. W. Pippin
Address: Elkton, Md
19. Mar 16 1947 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 15 19 47, at 5.40 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Shock.	
Due to: Fracture Left Femur & Fibula. Compound fract.	
Due to: Ft Tibia & Fibula Fracture Dislocation	
Other conditions: of left Ankle	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 3-13-47
Where did injury occur? Union (City or town) Cecil (County) Md (State)
Injured at home, farm, industry, public place (where?): Woods.
Means of injury: Aeroplane Injured at work?

23. SIGNATURE: H.E. Dodson M.D. M. D. or other
Address: Rising Sun Md Date signed: 3/15-47

Medical Examiner Cecil County

1-35

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

02730

CERTIFICATE OF DEATH

Reg. Dist. No. 926

1. PLACE OF DEATH:
County Cecil
City or town Elkton, Md (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Union Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County Cecil
City or town Elk Mills (If outside city or town limits, write RURAL and give nearest town)
Street No. — (If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME William Thomas Leth
3. (b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Annie Shepherd Leth
6.(c) If alive, give age 78 years
7. Birth date of deceased (mo., day, yr.): Oct 12 1868

8. AGE: Years 78 Months 5 Days 13 If less than one day ..... hrs. ..... min.

9. Birthplace Wilmington, Delaware (Town, county, and state)
10. Usual occupation Retired Postmaster
11. Industry or business

FATHER
12. Name John W Leth
13. Birthplace Maryland

MOTHER
14. Maiden name Elizabeth Marlsee
15. Birthplace Maryland

16. Informant Mrs William T Leth
Address Elk Mills, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 28 1947 (month) (day) (year)
Cemetery or crematory Methodist
Location Cherry Hill, Md.
18. Funeral director Joseph R. Grant
Address North East, Md.

19 Mar 27 1947 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1947 at 8:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1, 1946, to Mar 25 1947 and that I last saw him alive on Mar 25 1947

Immediate cause of death Myocarditis
Due to Arteriosclerosis
Due to
Other conditions Surgical operation Retention of Urine (Include pregnancy within 3 months of death)
Major findings of operations Hypertrophy of Prostate
Date of op. 7-1-46
Autopsy results

DURATION

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE H. C. Cenechy M. D. or other
Address North East Md Date signed Mar 27/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (85)

CERTIFICATE OF DEATH

02731

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Cecil
City or town: Colora Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all her 2 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Colora Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Dorthy Elizabeth Stiver

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	White	Divorced

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 8 1918.

8. AGE: Years: 29 | Months: 2. | Days: 21 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Perryville Cecil Co Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Jacob A Stiver
13. Birthplace: Perryville Md.

MOTHER
14. Maiden name: Louise Edna Starr
15. Birthplace: Chester Co. Pa.

16. Informant: Jacob A Stiver
Address: Colora, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 2 1947 (month) (day) (year)
Cemetery or crematory: West Gallingham
Location: Colora Md.

18. Funeral director: J. E. Tyson
Address: Rising Sun Md

19. April 1 47 (Date rec'd by registrar) 19 ..... Registrar

Permit issued April 47

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 29 1947, at 8 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Hemorrhage.	
Due to: Epilepsy.	
Attack.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 3/29-47
Where did injury occur: Colora (City or town) Cecil (County) Md. (State)
Injured at home, farm, industry, public place (where?): Home
Means of injury: Laceration Injured at work?

23. SIGNATURE: R. L. Dodson M.D. M. D. or other
Address: Rising Sun Md Date signed: 3/24-47

Medical Examiner
Cecil County

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

02732

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

Reg. Diat. No. 450

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Cecil
City or town Colora Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Cecil
City or town Colora Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Maud Way Doah

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widowed

6.(b) Name of husband or wife Arthur Doah
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 3. 1874

8. AGE: Years	Months	Days	If less than one day
72	3	3	..... hrs. ..... min.

9. Birthplace Colora Md. (Town, county, and state)
10. Usual occupation Retired
11. Industry or business

FATHER
12. Name Franks Way
13. Birthplace Cecil Co. Md.

MOTHER
14. Maiden name Mary Eva Killough
15. Birthplace Lancaster Co. Pa.

16. Informant Kenneth Doah
Address 96 Clendenny Ave. Jersey City. N.J.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 9 1947 (month) (day) (year)
Cemetery or crematory West Nottingham
Location Near Colora Md.

18. Funeral director J. E. Lyson
Address Rising Sun. Md.

19. ..... 19.. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 19 47 at 12 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15 1947 to March 6 1947
and that I last saw her alive on 2-27 1947

Immediate cause of death	DURATION
Chronic	
Due to Myocarditis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE R. E. Dodson M.D. M. D. or other
Address Rising Sun Md. Date signed 3-8-47

Consent received 3-8-47

1-35

Evidence for change of age shown on File B109 - 3/19/47 - B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (124-a)

CERTIFICATE OF DEATH

02733

cB

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: CECIL
City or town: PERRY POINT, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months 22 days
Hospital, institution, or street address where death occurred:
VAH, Perry Point, Maryland
How long in hospital or institution? 6 months 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1204 Euclid St., N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I

3.(a) FULL NAME: RICHARD HENRY WALSH

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): August 6, 1887

8. AGE: Years	Months	Days	If less than one day
59 ~~62~~	7	3	hrs. min.

8. Birthplace: Bayonne, N.J. (Town, county, and state)
10. Usual occupation: Plumber
11. Industry or business:
FATHER — 12. Name: John Walsh - Deceased
FATHER — 13. Birthplace: Tipparary, Ireland
MOTHER — 14. Maiden name: Catherine Cahalan - Deceased
MOTHER — 15. Birthplace: Co. Cork, Ireland
16. Informant: Hospital Records
Address: VAH, Perry Point, Maryland
17. Removal (Burial, cremation, or removal. Which?) Date thereof: Mar 10, 1947 (month) (day) (year)
Cemetery or crematory: Arlington National Cemetery
Location: Ft. Myer, Virginia
18. Funeral director: Pennington & Son
Address: Havre de Grace, Md.
19. Mar 10 1947 (Date rec'd by registrar) Irma E. Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 9, 1947, at 6:58 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 17, 1947, to March 9, 1947, and that I last saw him alive on March 9, 1947.

	DURATION
Immediate cause of death: Cirrhosis of the liver	Approx. 1 year
Due to:	
Due to:	
Other conditions: Psychosis due to alcohol, mental deterioration	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.: —
Autopsy results: No autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of: —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): —
Means of injury: — Injured at work?

23. SIGNATURE: A. E. Trollinger
A. E. TROLLINGER, M.D., Clin. Director
Address: VAH, Perry Point, Md. Date signed: 3-10-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

02734

Reg. Diat. No. 9C0

1. PLACE OF DEATH:
County: Cecil
City or town: Perry Point
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Perry Point
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1085 3rd St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary J. Whitaker

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Joseph W. Whitaker
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 28, 1870

8. AGE: Years	Months	Days	If less than one day
70	2	2	..... hrs. ..... min.

9. Birthplace: Port Deposit, Cecil Co., Md. Rural
(Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business

FATHER
12. Name: Edward T. Thompson
13. Birthplace: Cecil Co., Md.

MOTHER
14. Maiden name: Serena McMullen
15. Birthplace: Cecil Co., Md.

16. Informant: Mrs William S. Mackey
Address: 1085 3rd St., Perry Point, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 5, 1947 (month) (day) (year)
Cemetery or crematory: Hopewell
Location: Port Deposit, Md., Rural

18. Funeral director: Wm. A. Patterson & Son
Address: Perryville, Md.

19. March 5 (Date rec'd by registrar) 19 47 Truman E. Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 2 19 47, at 6A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept. 20 19 42 to March 1 - 19 47 -
and that I last saw her alive on March 1 - 19 47 -

Immediate cause of death	DURATION
Chronic Myocarditis	10yrs
Due to: Chronic Endocarditis	10yrs
Due to:	
Other conditions: Hypertension, Arterio-Sclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: E. W. Benson, M.D. M. D. or other
Address: Port Deposit Md. Date signed 3/4/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Z-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (91-a)

02735

CERTIFICATE OF DEATH

Reg. Diat. No. 920

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Union Hospital
How long in hospital or institution? 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Cecil
City or town: Rural Near Elkton
(If outside city or town limits, write RURAL and give nearest town)
Street No. RD 1
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Robert Williams.

3.(b) Social Security Number: 220-09-4505

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Wh	Married.

6.(b) Name of husband or wife: Ethel Williams
6.(c) If alive, give age 22 years

7. Birth date of deceased (mo., day, yr.): June 30, 1906

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
40	8	0		

9. Birthplace: Salisbury, Md (Town, county, and state)
10. Usual occupation: Painter
11. Industry or business

FATHER
12. Name: Robert T. Williams
13. Birthplace: Salisbury, Md

MOTHER
14. Maiden name: Emma Horner
15. Birthplace: Deals Island, Md

16. Informant: Harvey Williams
Address: 167 Hollingsworth Manor Elkton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 2 (month) (day) 47 (year)
Cemetery or crematory: Deals Island
Location: Deals Island, Md

18. Funeral director: H. W. Lupkin
Address: Elkton, Md

19. Mar 31 19 47 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 30 19 47, at 6 p. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 17 19 47, to March 30 19 47
and that I last saw h... alive on March 30 19 47

Immediate cause of death	DURATION
Bacterial endocarditis and Cardiac failure	60 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Orland W. Spear M.D. M. D. or other
Address: Elkton, Maryland Date signed: March 31/47.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-C

CERTIFICATE OF DEATH

02736

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 hours.
Hospital, institution, or street address where death occurred: Union Hospital Elkton Md.
How long in hospital or institution? 7 hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Caroline
City or town: Preston
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: /

3.(a) FULL NAME: Clara Estelle Wright

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	White	Single.

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 31 1928.

8. AGE: Years: 18 Months: 2. Days: 25 If less than one day: hrs. min.

9. Birthplace: Easton Md. (Town, county, and state)
10. Usual occupation: Student
11. Industry or business:

FATHER
12. Name: E. Orland Wright
13. Birthplace: Preston Md.

MOTHER
14. Maiden name: Clara Todd.
15. Birthplace: Preston Md.

16. Informant: Mrs. Clara Todd Wright
Address: Preston Md.

17. Burial (Burial, cremation, or removal—Which?) Date thereof Mar. 18, 47 (month) (day) (year)
Cemetery or crematory: Preston
Location: Preston Md
18. Funeral director: H. W. Pippin
Address: Elkton, Md

19. Mar 16 1947 (Date rec'd by registrar) J. R. Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 15 1947, at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Basil fracture of skull	
Due to Dislocation of 3 cervical	
Due to Vertebrae	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Accident Date of 3-15-47.
Where did injury occur? Chesapeake City Cecil Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Route 213
Means of injury: Auto. Injured at work?

23. SIGNATURE: R. L. Dodson M.D. Medical Examiner for Cecil County
M. D. or other
Address: Rising Sun Md Date signed 3-15-47

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